OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process**.

Testosterone Drugs - Non-Injectable

DRUG REQUESTED: Applicable box below **MUST** be checked to qualify or authorization process will be delayed. **Length of Authorization is ONE (1) Year**.

PREFERRED		
❑ **Androgel® Gel Packet**	❑ **Androgel® Gel Pump**	
Non-Preferred		
❑ **Androderm®** (patch)	❑ **Axiron®** (topical solution)	❑ **Fortesta™** (testosterone)
❑ **Natesto™ Nasal Gel**	❑ **Testim®**	❑ **Vogelxo™** gel/packet/pump
❑ **testosterone generic Androgel®**	❑ **testosterone gel/packet/pump generic for Vogelxo®**	❑ **testosterone generic for Fortesta™**

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Drug Name: ______________________________

Drug Form/Strength: ____________________ **Quantity per Day**: ____________________

Dosing Schedule: ____________________ **Length of Therapy**: ____________________

Diagnosis: ____________________ **ICD Code, if applicable**: ____________________

CLINICAL CRITERIA: **ALL** appropriate lines **MUST** be checked to qualify. Authorization will be delayed if not completed. Attach lab results with this request form.

Initial Review Criteria:

- Member is 18 ≥ years old; **AND**
- Member is male; **AND**
- Member diagnosed with primary or secondary hypogonadism**; AND**
- Member does not have a history of prostate carcinoma or male breast carcinoma; **AND**
- Prescriber has submitted the results of **TWO** separate serum testosterone levels, each drawn in the morning which indicate a serum testosterone level below the normal range within the last 6 months
- Testosterone, normal range = 300 to 1,000 ng/dL

(continued on next page)

- **Members who meet criteria should be approved for the <u>Preferred</u> drugs: AndroGel® Gel Packet <u>OR</u> AndroGel® Gel Pump first)**

Continuation of Therapy/Renewal Criteria

- Member has been compliant with treatment based on refill history
- Prescriber **<u>MUST</u>** submit labs indicating patient has a normal serum testosterone level on therapy (normal range 300-1,000 ng/dL) within the last 12 months

<u>Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.</u>

<u>Previous therapies will be verified through pharmacy paid claims or submitted chart notes.</u>

Patient Name: ____

Member Optima #: ______________________________ Date of Birth: ________________

Prescriber Name: ____

Prescriber Signature: ______________________________ Date: ________________

Office Contact Name: ____

Phone Number: ______________________________ Fax Number: ________________

DEA OR NPI #: ____

REVISED/UPDATED: ~~12/25/2017; 6/14/2018;~~ **8/31/2018**